

Division of Health Care Facilities		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:  TN7602		(X2) MULTIPLE CONSTRUCTION A. BUILDING 01 - MAIN BUILDING 01 B. WING _____		(X3) DATE SURVEY COMPLETED  12/05/2010
NAME OF PROVIDER OR SUPPLIER  ONEIDA NURSING AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 18805 ALBERTA DR ONEIDA, TN 37841			
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)		(X5) COMPLETE DATE	
N 002	1200-8-6 No Deficiencies  During the Life Safety portion of the survey conducted on December 5, 2010, no licensure deficiencies were cited under chapter 1200-8-6, Standards for Nursing Homes.	N 002				

Division of Health Care Facilities

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

STATE FORM

6898

3KYT21

If continuation sheet 1 of 1